



CITY OF BOSTON

COMPARISON OF HEALTH PLAN BENEFITS

Benefits in effect as of July 1, 2005

The purpose of this benefit comparison is to provide employees with a brief overview of the benefits offered by the City's group health plans. This comparison does not represent complete plan benefits. Each plan's benefits are subject to certain definitions, limitations and exclusions as outlined in the respective plan documents. Should any questions arise concerning benefits, plan documents will govern. For those plans that require members to receive care through a network of health care providers in order to receive benefits, refer to the specific plan brochures for the list of participating providers.

Medical Plan	Blue Cross Blue Shield Master Medical	Blue Choice	Harvard Pilgrim POS	Boston Medical Center Advantage	Harvard Pilgrim HMO	Neighborhood Health Plan
Monthly Premium <i>(health only-no life included)</i>	\$238.60 Individual \$553.52 Family	\$132.08 Individual \$340.76 Family	\$65.60 Individual \$176.44 Family	\$41.00 Individual \$110.32 Family	\$41.00 Individual \$110.32 Family	\$35.20 Individual \$94.84 Family
Deductible <i>(per calendar year)</i>	\$50 per member or \$100 per family - only applies to Extended Benefits	<u>In-Network:</u> None <u>Out-of-Network:</u> \$50 per member or \$100 per family	<u>In-Network:</u> None <u>Out-of-Network:</u> \$200 per member or \$400 per family	None	None	None
Out of Pocket Maximum	None	\$2,500 per member or \$5,000 per family, including the deductible, per calendar year.	\$1,500 per member or \$3,000 per family, excluding the deductible, per calendar year.	\$2,000 per member or \$4,000 per family annual maximum; Excludes durable medical equipment and prescription drugs.	None	None
Lifetime Maximum Benefit	\$250,000 per member for Extended Benefits.	<u>In-Network:</u> None <u>Out-of-Network:</u> \$1,000,000	<u>In-Network:</u> None <u>Out-of-Network:</u> None	None	None	None
Office Visits for Medical Care	80% coverage after deductible	<u>In-Network:</u> \$10 per visit (\$5 per visit for children under age 12) <u>Out-of-Network:</u> 80% coverage after deductible	<u>In-Network:</u> \$10 per visit <u>Out-of-Network:</u> 80% coverage after deductible	<u>BMC Advantage Network:</u> \$10 per visit <u>HPHC Provider Network:</u> \$20 per visit, referral required	\$10 per visit	\$10 per visit
Prescription Drugs <i>(must be purchased from participating pharmacies unless otherwise noted)</i>	80% coverage not subject to Extended Benefits deductible. Full coverage after reaching coinsurance maximum of \$200 per individual or \$400 per family. <u>Mail Order:</u> Up to a 90-day supply \$5/generic; \$10/brand name	<u>In-Network:</u> Up to a 30-day supply \$5/generic; \$10/brand name <u>Out-of-Network:</u> Covered at in-network level only for emergencies. <u>Mail Order:</u> Up to a 90-day supply \$5/generic; \$10/brand name	<u>In-Network:</u> Up to a 30-day supply: \$5 - generic \$10 – brand/formulary drugs \$25 – brand/non-formulary drugs <u>Out-of-Network:</u> \$5 - generic \$10 – brand/formulary drugs \$25 – brand/non-formulary drugs	<u>Up to a 30-day supply:</u> \$10 - generic \$15 – brand/formulary drugs \$30 – brand/non-formulary drugs <u>Mail Order – Up to a 90 day supply:</u> \$20 - generic \$30 – brand/formulary drugs \$90 – brand/non-formulary drugs	<u>Up to a 30-day supply:</u> \$5 - generic \$10 – brand/formulary drugs \$25 – brand/non-formulary drugs <u>Mail Order – Up to a 90 day supply:</u> \$10 – generic \$20 – brand/formulary \$75 – brand/non-formulary	<u>Up to a 30-day supply:</u> \$5 - generic \$10 – brand/formulary drugs \$25 – brand/non-formulary drugs <u>Mail Order – Up to a 90 day supply:</u> \$10 – generic \$20 – brand/formulary \$75 – brand/non-formulary

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Hospitalization	Covered in full	<u>In-Network</u> : Covered in full <u>Out-of-Network</u> : 80% coverage after deductible	<u>In-Network</u> : Covered in full <u>Out-of-Network</u> : 80% coverage after deductible	<u>BMC Advantage Network</u> : Covered in full <u>HPHC Provider Network</u> : Covered in full after a \$100 copayment per day up to a maximum copayment of \$500 per member per calendar year.	Covered in full	Covered in full
Routine Pediatric Care	80% coverage after deductible, less any inpatient visits used, according to schedule: 6 visits in first year (less any inpatient visits); 3 visits in second year; 1 visit per year age 2 through age 5	<u>In-Network</u> : \$5 per visit (\$10 per visit for children age 12 and older) <u>Out-of-Network</u> : 80% coverage after deductible according to schedule: 6 visits in first year (less any inpatient visits); 3 visits in second year; 1 visit per year age 2 through age 5.	<u>In-Network</u> : \$10 per visit <u>Out-of-Network</u> : 80% coverage after deductible according to schedule: 6 visits in first year; 3 visits in second year; 1 visit per year age 2 through age 6.	<u>BMC Advantage Network</u> : \$10 per visit <u>HPHC Provider Network</u> : Not covered	\$10 per visit	\$10 per visit
Adult Physicals	Not covered	<u>In-Network</u> : \$10 per visit <u>Out-of-Network</u> : Not covered	<u>In-Network</u> : \$10 per visit <u>Out-of-Network</u> : 80% coverage after deductible	<u>BMC Advantage Network</u> : \$10 per visit <u>HPHC Provider Network</u> : Not Covered	\$10 per visit	\$10 per visit
Emergency Room	Covered in full for hospital charges; 80% coverage after deductible for provider services.	\$25 per visit for approved emergency care; Otherwise, 80% coverage after deductible.	<u>In-Network</u> : \$30 per visit <u>Out-of-Network</u> : \$30 per visit for treatment of life-threatening illness or injury; 80% coverage after deductible for other care.	<u>BMC Advantage Network</u> : \$40 per visit <u>HPHC Provider Network</u> : \$40 per visit	\$30 per visit	\$25 per visit
Ambulance Services	80% coverage after deductible	<u>In-Network</u> : Covered in full <u>Out-of-Network</u> : 80% coverage after deductible	<u>In-Network</u> : Covered in full <u>Out-of-Network</u> : 80% coverage after deductible	<u>BMC Advantage Network</u> : Covered in full <u>HPHC Provider Network</u> : Covered in full	Covered in full	Covered in full
X-Ray and Lab	Covered in full	<u>In-Network</u> : Covered in full <u>Out-of-Network</u> : 80% coverage after deductible	<u>In-Network</u> : Covered in full <u>Out-of-Network</u> : 80% coverage after deductible	<u>BMC Advantage Network</u> : Covered in full <u>HPHC Provider Network</u> : Covered in full	Covered in full	Covered in full
Chiropractic Care	80% coverage after deductible	<u>In-Network</u> : Not covered <u>Out-of-Network</u> : 80% coverage after deductible	<u>In-Network</u> : Not covered <u>Out-of-Network</u> : 80% coverage after deductible	\$10 per visit for up to \$1,000 per member per calendar year for covered services received from a participating chiropractor.	Not covered	Not covered

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Durable Medical Equipment	80% coverage after deductible	<u>In-Network:</u> 80% coverage for up to \$1,500 per member per calendar year. <u>Out-of-Network:</u> 80% coverage after deductible for up to \$1,500 per member per calendar year.	<u>In-Network:</u> Same as Harvard Pilgrim HMO benefit <u>Out-of-Network:</u> 80% coverage after deductible.	<u>BMC Advantage Network</u> and <u>HPHC Provider Network:</u> Covered in full after a copayment of 20%, not to exceed a member’s total expense of \$1,000, up to a combined benefit maximum (both networks) of \$5,000 per calendar year, including member copayment.	Covered in full up to \$2,500 per calendar year.	Covered in full.
Home Health Care	Covered in full	<u>In-Network:</u> Covered in full <u>Out-of-Network:</u> 80% coverage after deductible	<u>In-Network:</u> Covered in full <u>Out-of-Network:</u> 80% coverage after deductible	<u>BMC Advantage Network:</u> Covered in full <u>HPHC Provider Network:</u> Covered in full	Covered in full	Covered in full
Physical Therapy	80% coverage after deductible for physical therapists' services in the office. Covered in full for services provided in a hospital outpatient department.	<u>In-Network:</u> \$10 per visit (\$5 for children under age 12) for up to 90 consecutive days per condition. <u>Out-of-Network:</u> 80% coverage after deductible	<u>In-Network:</u> Same as Harvard Pilgrim HMO benefit <u>Out-of-Network:</u> 80% coverage after deductible.	<u>BMC Advantage Network:</u> \$10 per visit for up to 90 consecutive days per condition. <u>HPHC Provider Network:</u> \$20 per visit for up to 90 consecutive days per condition.	\$10 per visit for up to 60 consecutive days per condition.	\$10 per visit
Vision Care	No coverage for routine care. Discounts on eyeglasses and contact lenses from participating providers.	<u>In-Network:</u> One routine vision exam per calendar year at \$10 per visit (\$5 per visit for children under 12). <u>Out-of-Network:</u> No coverage for routine care. Discounts on eyeglasses and contact lenses from participating providers.	<u>In-Network:</u> \$10 per visit <u>Out-of-Network:</u> No coverage for routine exams Discount on eyewear from participating providers.	<u>BMC Advantage Network:</u> Annual eye exam at \$10 per visit. <u>HPHC Provider Network:</u> Annual eye exam at \$20 per visit. Discount on eyewear from participating providers.	Annual eye exam at \$10 per visit	\$10 per visit Discounts on eyeglasses and contact lenses from participating providers.
Dental Care	Not covered	<u>In-Network:</u> Preventive dental care for children under age 12. <u>Out-of-Network:</u> Not covered	<u>In-Network:</u> Same as Harvard Pilgrim HMO benefit <u>Out-of-Network:</u> Not covered	None	2 preventive dental exams per calendar year, for adults and children. Thru age 12: No charge Age 12 & up: \$10/visit	Two preventive dental exams per calendar year for children under age 12.

Medical Plan	Blue Cross Blue Shield Master Medical	Blue Choice	Harvard Pilgrim POS	Boston Medical Center Advantage	Harvard Pilgrim HMO	Neighborhood Health Plan
Mental Health Outpatient	Biologically based - covered in full. Non-biologically based - covered in full up to 24 visits per calendar year.	<u>In-Network:</u> Biologically based - no visit limit. \$10 per visit Non-biologically based - up to 24 visits per member per calendar year. \$10 per visit <u>Out-of-Network:</u> Biologically based - 80% coverage after deductible. Non-biologically based - 80% coverage after deductible for up to 24 visits per member per calendar year.	<u>In-Network:</u> Same as Harvard Pilgrim HMO benefit. <u>Out-of-Network:</u> 80% coverage after deductible.	Biologically based – no visit limit. \$10 per visit Non-biologically based – up to 24 visits per member per calendar year. \$10 per visit	Biologically based – no visit limit. \$10 per visit Non-biologically based – up to 24 individual visits and up to 25 group therapy visits per member per calendar year. Not to exceed 25 visits combined. \$10 per visit	\$10 per visit
Mental Health Inpatient	Biologically based: covered in full in a general or mental health hospital. Non biologically based covered in full in a general hospital and covered in full up to 60 days per calendar year in a mental hospital.	<u>In-Network:</u> Biologically based: covered in full in a general hospital or mental health hospital. Non biologically based covered in full in a general hospital and covered in full up to 60 days in a mental hospital <u>Out-of-Network:</u> Biologically based: 80% coverage after deductible in a general or mental health hospital. Non biologically based; 80% coverage in a general hospital. 80% coverage up to 60 days in a mental hospital.	<u>In-Network:</u> Same as Harvard Pilgrim HMO benefit. <u>Out-of-Network</u> 80% coverage after deductible for up to 60 days per calendar year.	Biologically based – no days limit. Non-biologically based – covered in full for up to 60 days per member per calendar year.	Biologically based – no days limit. Non-biologically based – covered in full for up to 60 days per member per calendar year.	Covered in full.
Alcoholism Treatment Outpatient	Covered in full for up to 8 visits per member per calendar year.	<u>In-Network:</u> Up to 8 visits per calendar year \$10 per visit. <u>Out-of-Network:</u> 80% coverage after deductible, for up to 8 visits per member per calendar year.	<u>In-Network:</u> Same as Harvard Pilgrim HMO benefit. <u>Out-of-Network:</u> 80% coverage after deductible for up to \$500 per calendar year.	Up to 20 visits or \$500, whichever is greater, per member per calendar year <u>BMC Advantage Network:</u> Indiv. Visits 1-8: \$10 per visit Indiv. Visits 9-20: \$25 per visit Group Therapy: \$10 per visit <u>HPHC Provider Network:</u> Indiv. Visits 1-8: \$10 per visit Indiv. Visits 9-20: \$25 per visit Group Therapy: \$20 per visit	Up to 20 visits or \$500, whichever is greater, per member per calendar year Indiv. Visits 1-8: \$10 per visit Indiv. Visits 9-20: \$25 per visit Group Therapy: \$10 per visit	\$10 per visit

See last page for definition of Biologically based vs. Non-biologically based mental disorders

Medical Plan	Blue Cross Blue Shield Master Medical	Blue Choice	Harvard Pilgrim POS	Boston Medical Center Advantage	Harvard Pilgrim HMO	Neighborhood Health Plan
Alcoholism Treatment Inpatient	Covered in full for up to 30 days per calendar year in a substance abuse facility.	<u>In-Network:</u> Covered in full for up to 30 days per calendar year in a substance abuse facility. <u>Out-of-Network:</u> 80% coverage after deductible for up to 30 days per calendar year in a substance abuse facility.	<u>In-Network:</u> Covered in full for up to 30 days per calendar year. <u>Out-of-Network:</u> 80% coverage after deductible, for up to 30 days per calendar year.	<u>BMC Advantage Network:</u> Covered in full for up to 30 days per calendar year. <u>HPHC Provider Network:</u> Up to 30 days per calendar year; Covered in full after a \$100 copayment per day up to a maximum copayment of \$500 per member per calendar year.	Covered in full for up to 30 days per calendar year.	Covered in full.

Biologically based mental disorders – Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, and any biologically based mental disorders appearing in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance. Also, the diagnosis and treatment of rape related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape. For children and adolescents under the age of 19, the diagnosis and treatment of non-biologically based mental, behavioral or emotional disorders as described in the DSM.

Non-biologically based mental disorders – All other mental disorders not defined as biologically based disorders including the treatment of alcoholism or chemical dependency when the treatment is rendered in conjunction with treatment for mental disorders.